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ABSTRACT

This report of the WICHE (Western Interstate Commission for Higher Education) training institute on continuing education for physicians includes the following papers: "Historical Perspectives on WICHE's Continuing Psychiatric Education Program for Physicians," by Raymond Feldman, which examines how WICHE got started in the program, what it has done, and what it should try to accomplish in the future; "Use of the Physician Assistant," by Robert A. Senescu; "Psychiatric Problems of Physicians in Rural Areas," by John H. Waterman; "Long-Range Planning in Continuing Education," by Howard Kern; "Patient-Centered Teaching with Video Tape," by Robert I. Daugherty; "Patient-Centered Teaching without Video Tape," by Donald Naftulin; "Teaching and Learning Techniques," by Carl Pollock; two arguments each on the pros and cons of continuing psychiatric education for physicians; and a discussion summary by C. H. Hardin Branch. The volume concludes with an enumeration of unresolved issues, and plans for future training institutes. A list of the institute participants is included. (AF)

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Tenth Annual Training Institute for
Psychiatrist-Teachers of Practicing Physicians

February 5-8, 1970, Salt Lake City, Utah

WHITHER WICHE IN CONTINUING PSYCHIATRIC EDUCATION OF PHYSICIANS

Co-sponsored by the
Western Interstate Commission for Higher Education
and the
University of Utah College of Medicine

Edited by
Raymond Feldman, M.D.

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WESTERN INTERSTATE COMMISSION FOR
HIGHER EDUCATION
P. O. Drawer P Boulder, Colorado 80302
June 1970

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CONTENTS

Foreword v

Historical Perspectives on WICHE's Continuing Psychiatric Education Programs for Physicians 1
Raymond Feldman, M.D.

Use of the Physician Assistant 9
Robert A. Senescu, M.D., Discussion leader

Psychiatric Problems of Physicians in Rural Areas 11
John H. Waterman, M.D., Discussion leader

Long-Range Planning in Continuing Education 15
Howard Kern, M.D., Discussion leader

Patient-Centered Teaching with Video Tape 19
Robert I. Daugherty, M.D., Discussion leader

Patient-Centered Teaching without Video Tape 21
Donald Naftulin, M.D., Discussion leader

Teaching and Learning Techniques 27
Carl Pollock, M.D., Discussion leader

Panel—Pros and Cons of Continuing Psychiatric Education of Physicians 31
Raymond Feldman, M.D., Moderator
Edward H. Kowalewski, M.D., The Pro Side
Ronald Findlay, M.D., The Pro Side
Richard O. Panzer, M.D., The Con Side
John H. Waterman, M.D., The Con Side

Discussion Summary 45
C. H. Hardin Branch, M.D.

Unresolved Issues and Future Training Institute Planning 51

Participants 55

FOREWORD

This tenth institute was somewhat different from those previously held. The format was developed with the advice and participation of a planning committee consisting of the following physicians, who are leaders in the field of continuing education:

Herbert Fowler, M.D.
Robert Daugherty, M.D.
James Grobe, M.D.
Howard Kern, M.D.
Carl Pollock, M.D.
Robert Senescu, M.D.
John Waterman, M.D.

The theme of the institute was titled "Whither WICHE in Continuing Education of Physicians." This meeting examined how WICHE got started in this program, what it has done, and what it should try to accomplish in the future. Evaluation is an integral part of this program. We look at (1) results in regard to changes in attitudes and reported practices of physicians who have attended the seminars, (2) changes in methods of patient care, and (3) a state survey to determine how physicians see their needs for continuing education.

The results of this tenth institute were gratifying in that the discussions and the panel presentation were lively and provocative and brought out very favorable reactions about the conference on the part of the participants.

This is the tenth consecutive year the Western Interstate Commission for Higher Education has been involved with others to heighten the insight of western physicians about the emotional problems of their patients. This has all been made possible financially by a grant from the National Institute of Mental Health. The professional societies in the states have helped to develop course interest, content, and administration at the local level. The practicing psychiatrists in or near these communities who are willing to teach the courses have been provided an annual training session. The success of this model has been demonstrated by subjective responses, and also by an evaluation study which was in the hands of our valued co-worker, Dr. Judson D. Pearson of the University of Colorado.

There has continued to be an active collaboration between WICHE, the university medical schools, the American Psychiatric Association, and officials of state and local medical societies.

Another interesting feature has been the rotation of the cosponsorship by university medical school Departments of Psychiatry. This has been of much value, permitting all participants to learn from the large number of ideas developing in these different centers.

Ten years ago, when the WICHE effort began, there was no comparable program in the West. Now, practically every medical

school has a number of such courses with a full-time or part-time coordinator for continuing education in the mental health field. Many physicians in the West do not have access to these courses, and as a consequence, WICHE continues to concentrate on making possible postgraduate education in psychiatry to those isolated from training centers. WICHE has a vital role to play in continuing education, especially for the more isolated areas yet unapproached by medical schools.

As to the future, discussions showed the feeling that there is still a place for a small number of courses in the more rural and isolated areas at the request of the physicians. There are five western states without a medical school, and they may require assistance in developing and conducting courses.

Another challenge is that WICHE has never conducted institutes specifically for training program directors and coordinators. We have very strong feelings that occasional institutes of this type would be extremely useful and practical.

WICHE expresses appreciation to all the speakers, panelists, and participants for their efforts, and for sharing their thinking, thus bringing new insights to us. A special note of thanks goes to the University of Utah College of Medicine which co-sponsored the meeting and took a very active part in it.

Raymond Feldman, M.D.
Director, WICHE Mental Health Programs

Boulder, Colorado
June 1970

HISTORICAL PERSPECTIVES ON WICHE'S CONTINUING PSYCHIATRIC EDUCATION PROGRAM FOR PHYSICIANS

Raymond Feldman, M.D.
Director, WICHE Mental Health Programs

Prologue

I have been asked to present the major highlights of a historical perspective on WICHE's continuing psychiatric program for physician education, which I am happy to do. I have been involved with this program from a number of different vantage points, first as a staff member of the NIMH, next as the director of the APA physician education project, for many years as a member of the medical education committee of the APA, and more recently as a member of the APA's Council on Medical Education and Manpower Development. In this latter capacity, as well as in others, I have worked in liaison with many groups concerned with the continuing education of the physician and particularly with the Mental Health Committee of the American Academy of General Practice and the committee on liaison with medical practice of the American Psychiatric Association.

WICHE's psychiatric physician education project has been intimately intertwined with its mental health program generally. The project directors for the psychiatric education program have all been directors of WICHE's mental health program. They go back to 1959 when Dan Blain was WICHE's first program director. He held this job for a short period of time before he became California's director of the State Mental Hygiene Department. Then followed successively Warren Vaughan, Robert Hewitt, and Robert Dovenmuehle. I took over in July of 1966.

In 1959, Dan Blain first came to me to discuss this project—he as the newly appointed director of the WICHE Mental Health Programs and I as the chief of the Training Branch of NIMH. He had a great deal of conviction about the primary physicians and their role as one of the first to whom patients brought their emotional problems. He had an idea that there were sufficient psychiatrists in the West in many rural areas who could teach many things about the recognition of emotional problems and the importance of listening to patients, and thus help the primary physicians in dealing with early symptoms of emotional and mental disturbances. This is the idea that led to WICHE's *so-called* general practitioner program. I say, "So-called," because, while G.P.'s have always made up the largest numbers of participants, the program has always been open to any interested physician. When it began, there were practically no such courses, or programs, or efforts in the western states. Now, ten years later, practically every western

medical school has a number of such courses with a part-time or full-time program coordinator for continuing education of physicians in the mental health field. In many parts of the West, in spite of this, the medical schools find it impossible to reach some of the more isolated geographic areas. In these areas, where WICHE is able to provide some demonstration courses and programs, the physicians have responded enthusiastically and asked for more.

Beginnings

Roughly speaking, WICHE's efforts in the continuing education field for physicians have been in four main areas: (1) demonstration courses, (2) teacher-training institutes, (3) evaluation, and (4) liaison.

Demonstration Programs or Courses

In the earlier years, as many as 20 to 25 such demonstration courses were put on each year by WICHE with the help of many of you people who are here today. I will mention a few names. Please do not be offended if I omit many others, as I will have to do. These people include such pioneers in this field as George Schnack and Linus Pauling, Jr. from Hawaii; John Waterman and Bob Daugherty from Oregon; Allen Enelow and Don Naftulin from California; Jim Grobe and Otto Bendheim from Arizona; Richard Brown from Nevada; Dale Cornell from Idaho; George Gelernter and Winfield Wilder from Montana; J. Ray Langdon from Alaska; Herb Fowler from Utah; and Ed Smith from Colorado, just to name a few.

Over the years, courses have been put on in every one of the 13 western states. Generally, these have been conducted in small communities, but I often think they were picked because of their wonderful sounding names, such as Lebanon, Oregon; Wolf Point, Montana; Anacortes, Washington; Sterling, Colorado; Caldwell, Idaho; and Flagstaff, Arizona. They have also been conducted under special circumstances in Los Angeles, San Francisco, Portland, Reno, Honolulu, and Anchorage.

What has evolved through the years has been a ten-week course of roughly two to three hours each with one to two teachers and a participant group of approximately ten physicians. The format has been generally a beginning didactic period, usually very brief and sometimes omitted, followed by clinical case presentations and general discussions. The group leader or leaders have regarded their role primarily as informed, understanding, experienced persons who see to it that the discussions stay on target and who have the group continue to talk about clinical case material, problems, and issues in the handling of patients. What we have learned was what seems quite obvious: the

students who came back for a number of such seminars, those who completed two, three, four, or more such ten-week courses over the years, seem to profit greatly from them. In addition, many report changing their general style of working with patients even though their time with patients may continue to be rather brief.

Gradually the number of such courses offered by WICHE each year has diminished from a maximum of approximately 25 to something like six to eight per year. We have supported these and put them on only in areas that had no other means of doing it, and on subjects which were generally felt to be requested and wanted by the physicians who enrolled for the courses. This has included the field of child psychiatry, geriatrics, and specific subject matter such as marriage counseling and drug use and abuse.

Our feeling is that there is still a place for a very small number of such courses in the more rural and isolated areas at the request of the physicians. They frequently tell us that this is the only type of continuing education which is brought to them where they can really get it, at a time when they can participate. Medical schools have reached out tremendously over this period of time, away from the cities in which they are located, but they are not able to blanket every one of the 13 western states. There are still five states within the western region which do not have a medical school. These are Wyoming, Montana, Nevada, Idaho, and Alaska, and they may require assistance from time to time in devloping and conducting courses.

In an effort to be helpful, WICHE developed a brochure in the earlier years which served as a broad outline. On one subject it read:

> Teachers should be selected who have as broad a medical and teaching background as possible, and ideally should be (1) psychiatrists, preferably men practicing general psychiatry who have Board Certification or are Board eligible; (2) psychiatrists who are motivated and interested in teaching and who have had prior teaching experience; (3) psychiatrists who are aware of the broad role of the psychiatrist in the community, may have had experience in the consultant role, and have a willingness to cooperate with the non-psychiatrist physician; (4) psychiatrists who have an awareness of and interest in public health and social problems in the community; (5) psychiatrists who have a proven acceptance as a professional person by the local medical community, as well as by the community at large.

While these criteria were developed almost ten years ago, and we have notable exceptions, they still can be very useful. Over the years, by and large, the training directors and course coordinators

themselves have assumed full responsibility for the final selection of psychiatrist teachers and other physicians.

Other quotes from earlier brochures are as follows:

> The following steps were described to help develop local courses: (1) ascertain physician interest; (2) sign up course members; (3) arrange time and place; (4) take responsibilities for securing course accreditation as required; (5) review with teachers the plans for the course, including the instructor and content; (6) conduct as formally or informally as desired an evaluation of the course.

Also, in this same brochure the following appears:

> Most courses cover topics such as the following: (1) ordinary counseling techniques of the doctor-patient relationship; (2) the influence of family relationships on health and illness; (3) psychological effects of medical procedures, both harmful and beneficial; (4) psychiatric emergencies and the psychiatric referral process; (5) the use of drugs in psychiatric and current medical practice.

The course goals in the same brochure were described as follows:

> (1) increased ability to recognize and manage emotional mental disturbances in patients; (2) increased understanding of, and sensitivity to emotional factors in everyday practice; (3) increased skill in utilizing the physician-patient relationship as a part of the therapeutic process.

Teacher Training Institutes

In the first year of the grant, 1959, WICHE developed a teacher-training institute on a contract with Klaus Berblinger, M.D., professor of Psychiatry at the Langley-Porter Institute in California. This was an institute in which teachers from all over the West were brought together at Langley-Porter and were given an opportunity to discuss freely their aims, goals, methods, accomplishments, programs, and issues. Ever since then a similar pattern has been followed so that there has been at least one, and on one occasion, three teacher-training institutes each year conducted by WICHE and co-sponsored with one of the western university medical schools.

Thus, over the years, in addition to the Langley-Porter clinic, similar teacher-training institutes have been held at the following places: University of Southern California Medical School, University of Colorado Medical School, University of Utah Medical School, and the University of Oregon Medical School, all in collaboration with

the Departments of Psychiatry at these schools. More than 250 teachers of psychiatry have been involved in these institutes, and they, in turn, have reached almost a thousand physicians in the various courses they have taught.

While WICHE has included a great many training program directors and course coordinators who have also been teachers, WICHE itself has never conducted institutes specifically for training program directors and coordinators. We have very strong feelings that occasional institutes of this type would be extremely useful and practical.

Evaluation

Since the very beginning of the psychiatric physician education program, evaluation has been an integral part of WICHE's program. A contract for this purpose was developed in 1960 between WICHE and Dr. James Taylor of the University of Washington. He made use of consultants, particularly Dr. Charles Strother. Typical of their work is a brief statement from one of the first reports of this evaluation research:

> A first pilot effort evaluated the seminar results in a single community through before and after interviews with all participating physicians. The interview itself included questions on treatment methods, as well as the more usual attitude questions.
>
> They worked with the "before and after" interviews and analyzed them with particular attention being paid to changes in attitude and reported practices from before the course and afterward. As a result of considerable studies, Dr. Taylor and his group did develop reliable and brief scales for measuring attitudes of physicians. They identified the underlying factors in their studies: (1) the attitude toward the emotionally disturbed, (2) attitudes toward psychiatry, and (3) pressures of a busy practice.

During the years 1963-69, the evaluation studies for this program have been conducted under contract with WICHE by Dr. Judson Pearson, professor of Sociology at the University of Colorado, Boulder. The results of these studies have been presented in two monographs. I quote from the last paragraph of the second of these:

> In summary, our research findings indicate that short-term seminars in psychiatry for non-psychiatric physicians can be successful in stimulating for seminar participants a procedural change in their methods of patient care. Successful socialization is directly dependent upon the emergence of shared understandings, but if we are to expect success, psychiatrists and physicians alike must be willing to enter

into the common language process and accept the dual obligations of therapeutic exchanges as well as those of pedagogy.

One of the other major researches in this field has been carried out at the Staunton Clinic at the University of Pittsburgh by Lucy Zabarenko, *et al.*, supported by NIMH until recently. The kind of research which they did provided much needed information, but many more studies are needed in this field.

A very useful resource for finding what the physicians in the various states say they would like to have in the way of continuing education has been the statewide survey. As a demonstration during the past year, WICHE, under the auspices of the Colorado Steering Committee for Continuing Psychiatric Education of Physicians, developed such a survey for the 2,500 physicians in Colorado, the results of which were then analyzed and distributed widely. I'm certain most, if not all of you, received a copy.

We do not know of any better method of obtaining current information from physicians about how they see their needs in relation to continuing education. It also helps to indicate precisely in what topical areas the physician's needs seem to be.

Liaison

It is obvious from all I have said that there must be a great deal of liaison work on the part of any organization which attempts to do this sort of task. WICHE has had excellent cooperation from many national groups including the American Academy of General Practice, the American Psychiatric Association, and the American Medical Association. In addition, there has been considerable work done with the state and local components of these national groups, the state medical societies, county medical societies, district branches of psychiatric societies, and district branches and chapters of the American Academy of General Practice. Without the cooperation of the local groups, it would be very difficult to have a great deal of lasting impact. The liaison work necessary in a program of this sort can be very time-consuming, but it is extremely important.

American Board of Family Practice

No doubt most of you know that in February of last year, 1969, there was established a Board of Family Practice, the twentieth specialty, and the first to appear in more than 20 years. It will certify a new kind of practitioner whose development may require as much care, time, and study as the production of any other medical specialist. Part of the rationale underlying this development has been a recognition that medical science is fast approaching the point at which all future

physicians, without exception, will require extensive postgraduate education. Another factor undoubtedly has been deep concern with the dearth of family physicians occurring at a time when the need for personal, family-oriented care is gaining nationwide attention. Born during the period when the entire medical profession is confronted by the accelerating demands of scientific and social change, the new specialty will face untold challenge. At the same time, it will introduce a few challenges of its own. The American Board of Family Practice, for example, will be the first specialty board to require periodic recertification of its diplomates.

The new American Board of Family Practice has 15 representatives. Five are specialists, and ten are from the general field of practice. Five were chosen by the American Medical Association, General Practice Section, and five were chosen by the American Academy of General Practice. The other five are specialtists, including psychiatry, which I represent, and also surgery, medicine, pediatrics, and obstetrics and gynecology. The first examination is going to be given in three weeks in different parts of the country for two thousand applicants. Obviously, the early years will be very difficult to administer; that is, the planning for such a program will be very difficult. For example, at the present time there have been no residencies in general practice. Thus the applicants will be chosen from the field of general practice, but many other kinds of physicians will be eligible. In later years, only graduates of formal training programs in Family Practice will be eligible to take the examintion for certification. I also mentioned that there will be an examination for recertification. The details of this program have yet to be worked out, but it obviously has great implications for the entire field of medicine.

In summary, this presentation has been about how WICHE got started, what it has done, and where it has been. We really don't know what the future will bring, or even what it should try to accomplish. We hope this meeting will help in that respect. That is the challenge for all of us.

In closing, I came across a description of an educated man which intrigued me. So . . . I'll pass it along to you:

> An educated man never laughs at new ideas; cross-examines his daydreams; cultivates a love of beauty; always listens to the man who knows; knows his strong points and plays them; lives a forward and outward looking life; knows the value of good habits and how to form them; and keeps his mind open on every question until the evidence is all in.

USE OF THE PHYSICIAN ASSISTANT

Robert A. Senescu, M.D.
Professor and Chairman, Department of Psychiatry
University of New Mexico School of Medicine

The problem of the so-called physician's assistant is becoming an increasingly important subject. It certainly is not simply a manpower problem since it touches not only on how we define health and disease but, more importantly, what we mean by treatment or care and who may dispense it. As we all know, the physician is not renowned as a team worker and, indeed, often has considerable difficulty accepting help even from the existing allied health professions. Today we see emerging not only the physician's assistant, who usually has considerable conventional training, but, in addition, a new group of workers are being trained such as indigenous workers or new-careerists who show promise, despite their lack of academic background, of being able to contribute greatly in improving our health delivery systems. This is particularly true in the mental health area, although by no means confined to it. This new group raises many new problems. How the physician does or does not utilize assistance has many ramifications, not the least of which is the public health problem of the over-worked physician who, because he cannot utilize assistance, cuts down his productivity significantly, both in the short and long run.

Various questions were raised concerning the physician's assistant:

a) Does the term, "physician's assistant," itself perpetuate the problem, in part, if the goal of establishing teamwork between the physician and various colleagues becomes obscured by status considerations? That the physician should and must lead in various situations is unquestioned. Yet he probably also needs to learn to function as a team member as well as a delegator of responsibility to others.

b) The opportunities and responsibilities of new medical schools in educating different, more cooperative types of physicians who could serve more as teachers and consultants to various health workers was discussed at length.

c) New ways of utilizing the skills of the nurse, in particular, received considerable attention. It seemed to be agreed that we were not effectively utilizing the skills of the nurses we have now.

d) Inevitably, the discussion got around to the problems of private practice, economic and legal questions, and the problems of institutional and academic medicine. Considerable

open discussion focused on the question of the "vested interests" of the various health disciplines. It was more or less concluded that we all were just beginning to approach directly the problem of the delivery of care.

PSYCHIATRIC PROBLEMS OF PHYSICIANS IN RURAL AREAS

John H. Waterman, M.D.
Associate Professor, Clinical Psychiatry
University of Oregon, and
WICHE Field Consultant on G.P. Program

A Trial and Error Approach

When we began these institutes, I didn't know anything about postgraduate teaching of general practitioners. When you teach in medical school, you have a captive audience. Students look at the professor, and they respect him. But when you start teaching general practitioners, most of them know a lot more than you do. So you have to be on your toes, and you have to understand something about them and about their problems. I had the good fortune to get into this program as field consultant. I had the chance to travel just about all of the western states and to get to know the general practitioners, to cool my heels in their offices, waiting to find out if they wanted courses or not.

One of the big mistakes we made in the first place was that we started asking a lot of psychiatrist friends, "How would you like to teach courses to general practitioners?" They all said, "Oh, wonderful." We had a lot of volunteers. The only trouble was that the consumers weren't consulted as to what they wanted to learn. We psychiatrists were telling all these G.P.'s what they ought to know about psychiatry, and this wasn't what they needed to know. We taught what we thought they ought to know. We finally got smart, through the help of Jim Grobe and some of the others in AAGP, and thought that maybe we better start working with the Academy of General Practice and the physicians who were the consumers to improve our courses. We did this and, through the years, the courses did improve greatly.

Recognizing the Very Real Problems of Rural Physicians

You will hear today some of the problems we have, the teacher training techniques, the different kinds of teaching, and also some of the problems we face in bringing postgraduate education to rural areas. This has been my main interest because I have covered the rural areas, have been in close contact with the physicians in the rural areas, and know some of their problems. Many of the rural physicians were asked to come to this training institute and they couldn't come because they are under too much pressure in their communities. Some of them are working around the clock, and they just can't make it to a place like this, let alone take off time to get some postgraduate education.

This is one of the problems I am really interested in. How can we develop techniques to bring help to these physicians who are 200 and 500 miles away from the nearest medical center in order to help them expedite the delivery of medical services? This is one of the pressing problems we have today in health planning. We talked about whether rural physicians need to be educated. Maybe some of them in Montana, Idaho, and Nevada are getting along pretty well. We did decide that some of the things we must do to help the local G.P. in his psychiatric problems are to help him to cope with his own feelings, to handle psychiatric crises, to deal with the chronic neurotic, somehow to handle the volume of psychosocial problems that beset him, and to organize his own practice. But maybe we shouldn't push this down the throat of the rural physician.

We also accused the medical schools of not helping the students have a psychiatric orientation. Somebody in our group said that the G.P.'s that were graduating today weren't a bit different than the ones that graduated ten years ago. This is an indictment. If they aren't any better at recognizing human problems than they were ten years ago, somehow psychiatry in our medical schools is falling down in its effort to orient students psychiatrically.

One of the more optimistic notes, however, was presented by one of our group who is in a university training program and who pointed out that our present students are a lot differently oriented than previous students have been, really interested in human relations. We have medical students coming out of our clinic who are interested in working in the schools, working in the jails, and doing things unheard of, as far as medical students are concerned.

Not Enough To Make Doctor More Efficient

Our efforts in postgraduate education have been to make the doctor a more efficient doctor. The difficulty is that this is not enough. To illustrate, prior to this postgraduate study project for G.P.'s we had a traveling clinic for mental health. The clinic went into communities and gave certain services to help people with mental health problems. But the trouble was that this didn't work either because they didn't really involve the G.P. in the process, and, therefore, he looked at them as outlanders and foreigners. We came to a conclusion that what we really need to do is to help the doctor be more efficient by taking postgraduate education to the physician through teams, such as those Dr. McAllister has going out from the Nevada State Hospital. Another thing we have to do is to give him a resource that he can come back to to get help when he needs it.

Lastly, we felt that one of the more important points was that we have to help educate the community to some of the real problems

of handling some of the psychiatric problems in the community. With each step forward, new challenges and new issues present themselves. It might be likened to the great Arnold Gesell's description of a child's growth. He sits before he stands; he crawls before he walks; he babbles before he talks; he draws a circle before he draws a square; he lies before he tells the truth; he is selfish before he is altruistic; and in all ways he follows a definite pattern of growth which is distinctly and individually his own.

I don't know how far along we are in WICHE, but I do know that we are growing. One of the main issues that becomes clearer is the need for continuing education in psychiatry. All of you have had the copy of Bernie Bloom's and Jud Pearson's report of the survey of the Colorado Medical Society membership, and we find out that a high percentage of physicians are not aware of the psychiatric facilities that already exist and are available to them. We also know that only about ten per cent of the physicians are taking advantage of post-graduate education in psychiatry.

Our group was made up largely of physicians concerned with the vast rural areas—Montana, Idaho, and places where there are vast areas, and physicians and people are few.

We agreed that the general practitioner in these areas was more or less eager for help. This is also brought out in the report of Jud's and Bernie's. But the big problem is the delivery of teaching and the ability of rural G.P.'s to be able to take advantage of the teaching because of tight schedules and the overload.

We felt a lot of things could be said about need. We could ask questions like: Is part of our feeling that these physicians need help? Is that our own feeling, that we feel they really need it, or do they really need it? Is it a real need? What are the characteristics of different groups of physicians belonging to different specialties, and why do they enter these specialties? Do all graduates have the personality to respond to the postgraduate courses?

One of the things we talked about was how to help the G.P. get interested in postgraduate education. We decided there were four things that you have to accept in a rural area, that you have to do: 1) help the physician be more efficient and more understanding, the teaching part; 2) render some mental health service along with the education; 3) community education; and 4) a multiplicity of techniques should be involved rather than a multiplicity of programs.

Capturing Interest

We talked about an unresolved problem, how to get these physicians really interested. Two of our state hospitals, Nevada and Idaho, are thinking of starting some interesting things. They are in-

viting the G.P.'s to come to the hospitals, and they are feeding them. This is important in building up a liaison between the hospital and the rural community, which, in these particular areas, is about the only thing you have in mental health to reach the rural physician.

Another unresolved issue is: What is the private versus the public responsibility for delivering good medical care, including mental health? This needs a lot of thought and study. You know what has happened in some of the other programs. Unless the private sector of medicine does something about it, maybe a lot of it isn't going to get done.

The last unresolved issue is that psychiatrists have not trained teachers to understand the problems of the family physician or to think like a family physician. I'm going to conclude with telling you a story about how it works. A very valuable horse was lost in this particular town. They organized a posse to go out and look for this valuable horse, and the town dunce wanted to go along. They said, "Oh, no, you can't go. You wouldn't be any help and would just get in our way." The posse rode off early in the morning and left the poor kid sitting there, rejected, on the steps of the general store. They hunted all day and they couldn't find the horse. When they came back, here was the town dunce holding the horse. And they said, "Where did you find him? Where did you get him? How'd you do it?" He said, "I found him about a half an hour after you left. I just sat here and thought about where I'd go if I were a horse, and I went there and there he was."

LONG-RANGE PLANNING IN CONTINUING EDUCATION

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Real Problems of Planning

A characteristic of Americans and this speaker in particular is a reluctance to plan; especially long-range. We love to organize and systematize and scheme, but to plan thoughtfully ahead for years to come seems to take the spontaneity from daily activity. In addition, our daily chores seem so pressing and the value of planning so theoretical that little time is spared for what should be a continuing process. As physicians our lives of delayed gratification and what a teacher of mine once called "automatic existence," contribute to this reluctance to or lack of experience in planning. After all, once we sign up for medical school we need make no decision until the time of specialty training, and once that is embarked upon there is another automatic four or more years without real decision-making or planning. Furthermore, it is a lot more fun and simpler to plan for others than for oneself and this is what we have been about this weekend.

As this meeting culminates ten years of WICHE activity in continuing psychiatric education, it is appropriate to take stock and make plans. Our small group activity was designed as a simulation exercise in planning. Hopefully any teacher or program director might benefit from this exercise in view of his own planning needs. In addition, we sought to develop practical suggestions for WICHE.

Most planning is problem-solving and conferencing about specific dilemmas. Few of us ever have the luxury of the time without immediate responsibilities which is one of the prerequisites for long-range planning.

The Process

We used a planning process designed by Clifford C. Ham. The reader should go to the original article for a thorough discussion of long-range planning. This author/speaker is presenting a blurred carbon copy of Dr. Ham's thoughts. A summarizing quote from the article follows:

> Goals will change from year to year, as some end-states are reached, or new goals become desirable. The planning process must continue, with goals being updated, amended, revised, or in some cases rejected.
>
> Let us now review the several steps in this process. More steps will probably be necessary, but these are stressed.

1. Delineation of "areas of challenge and concern"; each group formulating goals must mark out its particular area of concern, rejecting other problems. (Note, parenthetically, that while it is tempting to start with statements about the philosophic base or about culture, a group can get bogged down in discussing abstractions.)

2. Statements of the ends desired. Each group, starting with brainstorming or with individual efforts, should collect all possible statements of desirable future states; then, the process will involve selecting those ends that are collectively desired, those that can most likely be attained, and those that fit in the three- to twenty-year span of time.

3. Preliminary checking and testing. Are there overlaps with other groups? What types of costs are we talking about? Are these costs realistic in terms of resources? Is it possible to develop a program which can reach this goal? What priority do the various goals have in relation to each other? In relation to other goals of other groups? What alternative programs are possible for each goal? What decisions are necessary to implement the programs?

4. Adoption of goals. What groups (or group) must discuss and give approval to these goals? What is the process of decision-making? Do we have "maximum feasible participation"?

5. Development of objectives and programs. Once more, goals will be carefully tested to make sure programs are possible. Costs versus benefits will be checked. Priorities will be determined.

6. Adoption of programs and approval of budgets. After this, the action phase can begin.

7. Evaluation. Early in the planning process, research methodology should be developed and tested so that the programs can be periodically examined and assessed as to their effectiveness in reaching the objectives and goals.

Our Goal

The overall objective of our small group discussion was defining the work of the WICHE Physician Education Project for the next ten years. Before discussing goals we had to have an agreed-upon philosophic base. Goals should follow from the philosophic base, values, and accepted conventions of the group. Otherwise trouble and conflict will develop as they try to implement the goals.

We spent some time talking about our commonly held values as

physicians interested in continuing education and examined our *societal data base*. By this we not only mean demographical and social data but, more importantly, the societal problems, the great issues. Out of this societal data base we then listed *areas of challenge* arising from what we knew about our *concerns*. From these arose our *goals* and *subgoals* and *objectives*. From a clear definition of goals, subgoals, and objectives we hoped to develop *programs* and *budgets*.

To try and impose this highly organized process on a group who are new to one another is extremely difficult. The first morning we allowed ourselves to "brainstorm" about our values. Our value system, we agreed, concerned the quality of life. This grew out of discussions about concerns on all of our minds today, that of the population explosion, the ecology, the impact of what we have done with our world, upon the quality of life. As physicians we have a concern for not just quantity in life but quality. This concern was expressed as a general sense of responsibility to do something about the quality of life and a conviction that the individual can influence his future and groups of individuals can influence their future. Also, we have a conviction that to survive, social institutions, social processes, and attitudes must be modified. We agreed that to do anything about these others issues, there must be some long-range planning. Those issues currently on our minds had to do with problems surrounding the family and marriage, drugs, crime and delinquency, population problems, race and civil rights problems, and all the miscellaneous social ills that we are aware of. We were concerned about the fact of diminishing human and physical resources. More narrowly we were concerned about broadening the definition of education as a means of assisting in the solution of problems. There was a consensus of concern about mental illnesses which, had time permitted, would have welded us into an effective planning group.

A Suggested Direction

From our weekend's examination and discussion of WICHE's past and future, several suggestions arose:

1. EMPHASIS
   The emphasis in the WICHE Physician Education Programs in the past has been on aiding primary physicians in the care of the emotional factors in individual patients. *A new focus* for the WICHE programs might be upon the education of physicians in skills of *consultation* and leadership so that they can provide needed leadership to their communities in executing programs related to the development of mental health.

2. PLANNING
   A prerequisite for planning, organizing, and evaluating a long-range program is the development of demographic and societal data for the WICHE region. Much of this is already in existence. By collating it and filling in needed knowledge through additional studies, an understanding of the public health and physician education needs would be enhanced.
3. DEMONSTRATION
   As in the national program insufficient funds are spread thinly over a wide area. We felt that it might be more effective, in the long run, if there were a concentrated expenditure of resources in a limited area; in order to demonstrate clearly to leadership in the entire area the need and effectiveness of continuing education in psychiatry for the primary physician. Hopefully, such a demonstration would result in increased funding by all states.

As an exercise in planning, this brief meeting was often an exercise in frustration. If I had it to do over again, I would strive to do the following: 1) prepare myself better in the theory and practice of planning; 2) begin to build the planning group through preliminary correspondence, conversation, and references to literature; 3) gather more information and recruit more people knowledgeable about the area for which we are planning; 4) have an agreed-upon planning problem that excites all members of the group; 5) allow for considerably more time for the group to become cohesive and to proceed through the various stages of group life needed to accomplish the planning process.

PATIENT-CENTERED TEACHING WITH VIDEO TAPE

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As I became involved in this program, one of the real concerns was: What kind of product are we going to turn out? If you take a good general practitioner, or internist, and inseminate him with some psychiatry, what kind of a product is this going to turn out?

Our biggest problems have been that (1) we have had some "drop-outs," G.P.'s that turned into psychiatrists, and (2) our teaching machine is not very efficient. As near as I can determine, about half of the people we sign up probably come out the kind of product we would like to see, and my chief concern is increasing the efficiency of the machine. We recruit good teachers, there is no question about this. The criteria that were outlined by Ray are the way that we select teachers, and the persons that we select by that system come with certain problems. One of these, as I see it, is that the teachers need to learn to deal with small group process—particularly, small group process among physicians. As I see it, the techniques that we are using now are too constricting as opposed to giving freedom to the physician. That is what we are going to focus on in the group that I am in. We are going to get feedback television to try to evaluate that sort of thing.

Stimulation Needed Most

Looking over the years, one of the greatest teachers we had was Bob Johnson who died a couple of years ago. When you asked Bob what he needed to be a better teacher, he said: "I need stimulation, I need new ideas, I need new techniques, I need intimate contact with the people I am teaching and with my peers in the teaching process." In some way we need to provide that kind of experience for the teachers.

Just a word about our product. There are some real products in this room that have come out of the WICHE courses over the years. Bill Galen, the internist from Portland, came up with a statement at one of the meetings he attended:

"I used to think I was treating diabetics, and persons with GI disease, and that sort of thing; now I see that at least 80 per cent of my patients are persons with emotional problems who incidentally have diabetes and GI problems."

Two other excellent products are Virgil Samms and Ron Findlay. These gentlemen have been in a course that has gone on for a long time in the Eugene area. When you look at these outcomes of a very intensive process, you can't be anything but excited and overwhelmed. Other persons in the room, I know, are men who have sincere dedication to this teaching process. To me it is a very exciting thing that the persons involved in this are so intense.

This was illustrated by an unusual meeting we had in Oregon. We had a teacher-training session. We spilled blood all over the floor, and we had to have a mop-up session. We realized then that this was the first time we had ever brought the teachers together without some outside "big firemen" coming in to tell them what to do. We found that we have some of the answers to the internal problems. As for unresolved issues, television and patient-centered teaching, the issue as I see it is efficiency. It takes a tremendous amount of organization and effort, material, time, and money to do television.

In the evaluation of whether this is worthwhile or not, you have to put effort over output, and we got a tremendous amount of output out of this group this weekend. I don't know how you measure the learning game, but it was tremendous. The group people kept saying, over and over again, "I'm seeing new things." The attendance was out of this world. For the regular sessions we had only one drop-out, and that was for half a day. We had extra meetings in addition to the scheduled meetings. On Friday night we had an extra meeting to watch tape. We had a special meeting, a luncheon meeting, to which everybody came; in fact, four extra people came to that one. Then part of the group went to the play which was a continuation of our considerations. At one time we had 22 people in this room watching what was going on, so I think we can say this was a tremendous attraction.

PATIENT-CENTERED TEACHING WITHOUT VIDEO TAPE

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Education Needs of the Rural Physician

In discussing its assigned topic, our group primarily considered the educational needs of the rural physician. The group agreed that those needs are often defined in terms of the community in which the physician practices. Course content is geared to the self-perceived needs of the physician coursetakers, but to an equal extent and with increasing importance, to the medical needs of the community which they serve. Postgraduate courses, then, should be fashioned to community health care services and continuing education effectiveness assessed by changes in health care delivery following those courses.

The group noticed that there is a recent change in our terminology. Rather than postgraduate education of the non-psychiatrist physician, we are starting to talk more about the continuing education of the physician. Instead of seeing a course as a one-shot experience, we are really viewing it as in integral part of ongoing education in which physicians will incorporate self-assessment methods into their practices. Perhaps this is more than we can expect, but certainly this is one of the goals we have. And, it is the goal of some state medical societies. Compulsory continuing education requirements must be met to sustain state membership in Oregon, Pennsylvania, and California Societies. It is highly doubtful whether most physicians are sufficiently self-motivated to continually educate themselves. What processes must we undergo to get the physician in the rural center to test continually his therapeutic principles and to question the knowledge he graduated with? Once he graduates from medical school, the half-life of a doctor's knowledge is less than five years. Can we increase that half-life without more effective programs? Is compulsory re-certification one answer to greater participation in educational programs?

Find Only What We Look For

In carrying through Pasteur's principle that we find only what we look for, one question arose as to how we might attract those physicians who don't look for emotional problems in medical practice. Is it really necessary for us to try to find these physicians? Do we not have our hands full trying to educate, counsel, remotivate, and develop some group reinforcement with those physicians already sensitive to these issues so they may feel more comfortable and act more effectively with their patients?

We just might increase the interest of the uninterested physician, however, by getting an assessment of what he sees as the socio-medical issues of his community and sponsoring a two-day conference on a particular issue. Current issues include drug abuse, the problems of adolescents, sex and the family doctor, violence, abortion, poverty, and the multi-purpose health center. If the physician can be sensitized to these issues, if he already has a nagging doubt about where society is going, we as educators might entice him into an ongoing educational process by conducting programs which will allow him to learn more about the issues.

In the afternoon we talked largely about procedural aspects of teaching without video tapes. There are sociometric interaction analyses supporting the hypothesis that a low authority, low rigidity physician may facilitate greater anxiety reduction in a patient than a physician who is directive and more highly authoritarian. If such qualities are a desirable part of the doctor-patient transaction, perhaps we psychiatrists can demonstrate such style to the non-psychiatrist. This can be done by means of the case conference interview, the bedside consultation, or the office consultation where we can observe the physician practice.

We are concerned about the content of what the physician learns: drugs, schizophrenia, suicide, family problems. We talked about the techniques of interviewing—getting a physician in private practice to identify when and how he confronts a patient, when he supports, when he interrogates, when he interprets, when he facilitates, and how he intervenes. Teaching interviewing techniques and use of drugs are different goals. How we institute them without the use of video tapes was our concern.

Comprehensive Community Health Centers

We talked about getting the physician more mobilized toward the acceptance of comprehensive community health centers and multi-purpose health centers, and whether this should indeed be a goal of continuing education. We finally came to the conclusion that, in the absence of a live, warm patient who is going to fit the particular substantive talk that we educators have prepared for that day, it is better to get a dramatized, not over-dramatized but dramatized, technically good, photographically sharp tape of a patient representing that particular problem. In other words, if a designated patient isn't available, rather than just getting any patient who doesn't necessarily represent the topic, one is better off bringing a video tape into the session. We started out talking about teaching without video tape. We wound up saying that it is one of the more effective teaching methods that we have at this time.

We concluded our afternoon session by discussing evaluation. In our group a number of physicians in family practice felt that we at the universities stress evaluation excessively. When 20 per cent of our grants are earmarked for evaluation of our teaching effectiveness, it may seem excessive. Some might say we really should devote more time to actual teaching and more time to more effective delivery of health services. $1.2 billion has been cut out of the Health and Education budget. Five million of that is said to be coming out of the NIMH budget. Many of us fear this cut will be felt in the evaluation of our teaching effectiveness. It is important that those of us doing this work must continually question whether what we are doing is worth the expenditure of time, personnel, and tax dollars. If we evaluate our effectiveness as to how well the community utilizes service and how people are helped, I think we can say whether or not we do a fair job in continuing education. Yesterday, John Waterman said that it costs about $200 a trip to come to some of their courses. It costs others $300-$400 a trip. When we reach ten physicians at a cost of $5000, we must evaluate just what we are doing. We have national priorities and must assess whether we are really doing that much good. This is one of the tasks in continuing education for the non-psychiatrist physician. We're entering another decade in which we must evaluate how effective our educational delivery system is by its effect on health care.

Cost Is a Factor

We discussed computerized, packaged, programmed, and vacation learning. All suggestions were far too extensive and un-tested to be included in this group report. But a two- or three-day vacation setting educational program was thought by most of the group to combine a relaxed atmosphere with a more highly motivated group of learners. This combination in some programs has demonstrated no immediate loss of cognitive learning compared with standard two-day conferences. More important, it serves as a greater incentive for those physicians who otherwise might not partcipate in continuing medical education.

The question arose as to whether a twelve-week course is really necessary. What about the possibility of having two-day courses separated by a weekend or two consecutive weekends, or even two three-day courses? This would mean the instructor coming from the medical center can actually see the physician in a group in the morning and then stay the rest of the time in one of the physician's offices. This is one of the innovative ways of trying to get more effective education, trying to get those who ordinarily wouldn't take the course, to become involved. Each time the instructor does this, we suggest that he be in the office of a different physician, and that the visit be structured as a

learning experience for the psychiatrist as well—a two-way educational process.

Encouraging Participation

We discussed how we might involve the physician to work with associated professionals, paraprofessionals, and indigenous nonprofessionals. Many of us are frightened by the prospects of consumer determination of health care. But the handwriting is on the wall whether we like it or not. There will be more non-medical people involved in planning councils, regional medical programs, comprehensive health care programs. It seems as if the federal government is very concerned about doctors' willingness to plan and practice on a more egalitarian basis. At future WICHE meetings, there might be some possibility of recruiting physicians who are reluctant to work with allied professionals by creating some incentive to do so. One incentive suggested was if the physician brings a clergyman or indigenous nonprofessional, he gets a tuition reimbursement. This was done in Colorado and apparently worked with some success.

Another suggested recruitment method was to send invitations to the staffs or the wives of the physicians in hopes that they would become interested in some of the socio-medical problems discussed, then get the physician himself to attend. This is a more expensive way of recruiting; it takes a lot of training money. When you send an embossed invitation, RSVP, to a wife, it costs considerably more than just a flyer going through the mail. The merits of these ideas should be weighed.

The group felt we don't really know to what extent we teach psychiatry. There are those among us who believe that psychiatrists are probably born and not made. There are those among us who feel that we shouldn't be teaching psychiatry as psychiatry to doctors. Perhaps the best we can do is take the skills physicians have, the skills they bring to their own profession, and enable them to utilize these skills more fully. How do we do this? There are a number of people who feel that perhaps psychiatry has more style than substance, and yet when we teach style we get the same type of criticism that Rich Panzer talked about yesterday. Physicians say, "This is very interesting, but I'm not in it just to be a friend to a patient. The doctor-patient relationship doesn't thrill me that much."

Balancing Style with Substance

Leston Havens said that psychiatry is a sometimes practical art in search of a scientific base. In order to win the uninterested physicians into some liaison with us, to try to teach them to deal with patients as people and not necessarily as objects of pathology, we have to try

to provide that scientific base and provide it very early as the means of seduction, as a means of telling them: "Yes, we know how to talk your language of drugs; we know how to effectively use drugs, and maybe we can help you." We could use the hard data of drug treatment as a springboard into other areas of human relationships. Maybe this is what we have to do, balance style with substance. In order to do this we must have skilled instructors who can teach substantively as well as preceptively. Perhaps in future WICHE meetings we can bring these instructors in, split into groups, and actually demonstrate a course. Other conferees could act as physician course-takers. Also, those of us actually providing and teaching courses might video tape some courses and demonstrate them.

In summary, the group concern was: we must provide more adequate training of the educators. This is what WICHE is trying to do. To evaluate our effectiveness we can determine whether the community in which the course was taught actually received better health care. We are trying to teach doctors how to take care of their own patients and on the other hand, some of our better educated doctors say, "Now that I have taken these courses, I am referring more patients out." The group was not certain that more psychiatric referrals is one of our goals in the continuing education of non-psychiatrist physicians. What we really want to do is alleviate emotional conflict of patients seen in medical practice. To do this, it is important that we differentiate problems of living from psychiatric problems.

We in psychiatry deal on a highly inferential level. We don't often conceptualize illness in terms of functional capacity but rather how a patient might feel. Many patient feelings that are experienced in an office practice are inevitably problems of living. If we identify most conflicting feelings as "psychiatric," we're going to try to deliver psychiatric services to everybody, a task which is insurmountable and unrealistic. The patient needs an understanding, humane, professionally competent provider of health care services.

How Long?

Will the rural M.D. as well as his patient tolerate inadequate health services? Will they tolerate second-rate patient care? They may tolerate it, but not for very long. Rural America, like urban America, is experiencing a ground swell of protest about the delivery of health services. The new physician is responding to that protest by providing low-cost care in many rural areas. If continuing education is available to him, if we provide incentives for his education and his involvement, high quality care can be realized.

TEACHING AND LEARNING TECHNIQUES

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Focus

The purpose of this group was to focus on the problems of deciding on content and methods of teaching general practitioners. The group decided to bypass the general question of what the practitioners felt they needed to be taught and addressed ourselves to finding some common denominators in the areas of content and method.

Therapy or Consultation

We saw, in a general way, that previous courses seemed to fall into either the area of group therapy, which produces something which has been termed "attitudinal change" on the part of the practitioner, or a type of teaching which one might term a repetitive consultation. It seemed that somewhere in between these extremes we could find a more useful vehicle for teaching and learning, distilled from our experience.

Our approach was to avoid teaching situations in which there was no planned structure. We began with a discussion of the value of teaching general practitioners how to understand exactly the patient's own view of his illness. The question was raised as to whether or not one could really teach the practitioners how to get patients to reveal enough about themselves so that they expressed their own personal view of their illnesses, rather than accepting a view which followed a preconceived notion of the practitioner. In order to produce this spontaneous account of their feelings about their illnesses, we discussed methods of teaching a certain categorization of the life styles of patients.

I presented a summary of this interpretation, along with suggestions about how the practitioner might modify his responses to various life styles in order to reduce anxiety and defensiveness on the part of the patient. It was hoped that the practitioner could recognize certain broad categories of behavior related to illness which produce anxiety in his patients, minimize that anxiety, and thereby attain a spontaneous account of the very personal and psychological reactions that the patient has to being ill. It was hoped that in this context a third principle could be proposed, having to do with the identification of the important, dependent, other person in the patient's life with whom there is some conflict or modification of the relationship. Using this principle it was hoped to avoid having the practitioners accept the rationalizations that patients offer when they discuss anxiety. To simply assume that a patient will agree that he might be anxious be-

cause of his job is to avoid a discussion with the patient of the relationships which are such an important part of reaction to illness. It was hoped that these principles could be presented to the practitioners in a way which could be useful to them without generating a lot of resistance.

A Modification

For the last principle or, rather, generalized admonition, had to do with avoiding discussion between doctor and patient of some kind of intellectualized relationship of presenting symptomatology and psychological conflict. It was felt that generally this resulted in an increased resistance on the part of the patient and it produced few benefits. In general, the suggestion was to allow the patient to modify his need to present the physician with symptoms as they talked about his conflicts with other people important to him in his life.

There was a lot of discussion about how much of our teaching had produced attitudinal change, but it seemed that change occurred only after some five years of repeated contact with courses. We discussed whether this attitudinal change might not be accomplished better by therapeutic experience, rather than by what we had felt was training. Many interesting points were brought up concerning whether or not this change occurred to physicians without their knowledge. Another interesting question was raised as to their ability to apply this attitudinal change in the course of working with patients.

Interaction a Goal

We also felt that it was necessary to conceptualize for our physician practitioners just what the goal of the interaction with their patient is. Two important principles were mentioned here. One is the goal of allowing the patient to discuss freely his conflicts with others and to express his feelings about them. The second important point was to recognize that the practitioner should help the patient clarify the conflict with which he is most preoccupied. In so directing our efforts, it is hoped that we can teach the physicians that there is an end point and a goal which they can keep in mind in working with patients, in order to avoid leaving the physician with the impression that he is to supply a never-ending source of support to his patients without seeing much change. These points were discussed in relationship to a challenge for the instructors to keep in mind continuously that they should be identifying for themselves and for their students the area that is the learning problem.

For many practitioners this would mean acquiring an ability to place his patient in a situation where the patient can tell the physician an optimum amount of information about his life and his struggles

with others. The second area that could be defined as a learning problem or challenge would be to have the physician understand as best he can what the patient is trying to tell him. The third broad area would be that of helping the physician conceptualize what he is going to tell the patient. These concepts were borrowed from the models of teaching psychiatric residents; it was felt, nevertheless, that they were germane to working with any physician dealing with emotional problems in his patients.

Conceptualizations Useful as Models

Finally, we discussed some of the newer challenges. In relation to these challenges we felt that we should be addressing ourselves to ways in which we can make the best use of learning and communication theory or techniques of experiential learning in teaching general practitioners. It was not felt that we had solved all the problems in the short time we met discussing teaching and learning techniques, but we did feel the conceptualizations described here would be useful in providing models which could be further amplified and modified in improving our methods and approaches to teaching.

 (no p. 30)

PANEL - CONTINUING PSYCHIATRIC EDUCATION OF PHYSICIAN

THE PRO SIDE

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Improving Health Care the Goal

The ultimate aim of continuing medical education is to improve health care of the patient. Continuing education should make it possible for each physician to use in his practice the modern medical knowledge that continuously becomes available. Adequate professional growth ensues through the participation of each physician in suitable programs of continuing education in addition to his own experiences and readings.

Continuing education should be favorably augmented and modified following an adequate initial education. These programs should make possible the acquisition of such new skills and knowledges as a physician requires to maintain competence in his chosen field. All continuing education should strengthen the habits of critical inquiry and balanced judgment that denote the truly professional scientific man, and the reward for participation in continuing medical education should always be improved ability to take care of the patient. Postgraduate education is the responsibility of the medical school, the community hospital, and the practicing physician.

The American Academy of General Practice has conducted a very extensive review of everything that we have done in the area of postgraduate education, in postgraduate education of mental health, in our hospitals, and in the general increase of postgraduate education by our membership at large. Without a doubt, what we have done in mental health postgraduate education has been right.

Up to this point, in medicine we have been primarily concerned about saving lives. We will have to continue to do this, certainly. But if we are going to improve the care of the patient, we have to improve the *quality* of his life. I sincerely believe that in the area of psychiatric concern and the family physician, quality of life and understanding has much to do with continuing education in psychiatry.

Peer Review

One of the biggest topics today is so-called *peer review*. Peer review has three components, one which has to do with fees, one which has to do with utilization, and one with quality. Quality is a very great concern to our society. People will contend that peer review is still the right of the physician; that we are doing a good job in a

hospital or other institution where we can have indices of quality. But they ask, "What are you doing in the individual physician's office?" Fortunately these are people who will still agree that once you get into the domain of personal life on a one-to-one basis to do controls, you do indeed have a job. But they ask, "As organized medicine, what are you doing about it?" We can say that medical organizations concerned with quality are attacking this from the point of view of education, postgraduate education. If you can educate properly, you are going to affect the quality in the individual office.

One other thing that we have to be concerned about is *consumer involvement*, those large groups who have much control in this country. For example, organizations of retired people are concerned about the consumer wants and need to be assured of quality care. If we are serious as physicians as to our responsibilities to the people, the greatest responsibility that we have is to be the guardians of the health of the community. We have had some problems with individuals in medicine. I call to your attention one fact: In the United States, a man can graduate from a medical school, get as little as one year internship, and go on out and practice, and unless he commits mayhem, he can go any direction he wishes. Many of these individuals, not as many as we thought after a recent study, do not even belong to one hospital staff. So if we are serious as a medical community, our responsibility is to assure the health care of the community and insist, along with other measures, that each practicing physician be a member of at least one hospital medical staff.

Reason for Optimism

I am optimistic. When any one segment of organized medicine identifies a problem and is willing to do something about it, suggests a way to do it, it is the duty of organized medicine to assist. I think I see this happening. If, indeed, we're going to do something in education from now on, there are some barriers that we have to break. If we think that we are going to go on with meaningful postgraduate education in the same manner that we have been doing with the sit-down didactic method of teaching and the same kind of reward—a piece of paper on the wall—if, indeed, our end is going to be to get every physician to participate, that isn't going to work any more. We have to learn to teach on the job. We have to learn to teach in the hospital, we have to learn to teach as the man is working, and we have to be able to learn not to take away from his time in attending to people.

I challenge you that the rewards have to be different. If we are going to make postgraduate education meaningful from now on the reward system has to be different.

Because of all the advancements in medicine, the volume of knowledge is so great that we hear that you can't know it all. This is an old saw that we must get rid of, because no physician is expected to know it all. The problem is that we have not had the quality of teacher who can discern what is necessary to learn from the whole bag, and teach that. This is one of our problems. We must find the teacher with the technique of picking out what is necessary and teaching that.

There is no single way to teach, there are myriads of methods which you are going to have to continue. One man learns on a one-to-one basis, one man learns in group, one man learns in small group, one man learns by reading, one man learns by looking. Technology, modern technology, has opened the door of many beautiful things that are being done to assist educational efforts.

Dr. Feldman serves on our committee of examination for the new specialty of Family Medicine. We have worked for two or three years developing a new kind of examination. The exciting thing to me is that we will be able, in about a year, to not only use colored movies in our examination for Boarding, but also be able to bring in meaningful verbal exams with the movie. We can teach and examine such things as counseling and interview. But we have to break some barriers here, also, because in our experience we were required to use the term "re-boarding by re-examination." We were advised to stick to re-examination because the powers-that-be who were going to decide whether we were going to be a specialty or not would not accept the fact that we could document—that there will be many ways of re-evaluating which do not have to use the old method of re-examination.

University Without Walls

Finally, the concept of the university without walls is not new but is getting more meaningful every day because of the continuing association of a physician with the university or his institution of residency. This association has the potential of developing some of the most interesting and most encouraging new ways for us to make innovations in the area of postgraduate education of the future.

THE PRO SIDE

Ronald Findlay, M.D.
Eugene, Oregon

The G.P. Speaks

I am a Eugene, Oregon, G.P. with a background in boiler making, flying, education at Reed College in Portland, and graduation from the University of Oregon Medical School in 1952. Those of you who know the University of Oregon Medical School of that vintage will recognize that our psychiatric training was given to us by a group known as the Dickle-Dickson group. If you know these gentlemen you will be acutely aware of the fact that my psychiatric education was a 50-50 proposition—50 per cent from Dr. Dickle on how to stuff a pipe, and 50 per cent from Dr. Dickson on how to relax patients.

I interned at Sacred Heart in Eugene in 1952. Shortly after I arrived in Eugene, I became acutely aware of how poor my psychiatric background was. It was demonstrated to me by one of the nuns. We had a little, short, chubby nun who helped me out in a psychiatric problem. One of the patients was having a bit of paranoia along with myxedema. She was in the center hall at the time that people were leaving during the evening visiting hours. She stood there and, in a croaking voice, said, "They are using me for television; everything that I see goes out on television." This really didn't bother her too much except that they weren't paying her for it. This really upset her. She said they were putting things in the water to poison her. So I said, "Let's go upstairs and talk about it." She wasn't about to leave the center hall because she liked it there. Then she said, "I'll go if Sister Superior will take me." Down the hall came this little, short, chubby nun, Sister Mary Louise, and I said, "Sister Superior, I need some help." We agreed that she was Sister Superior, which she wasn't, and we went up to one of the locked rooms where we were going to hide this patient. I went down the hall and picked up a couple of quarter grain thyroid tablets and half a grain of phenobarb. I gave them to the lady and she said, "They are poison, I won't take them." As I was trying to get her to take the pills, she looked up, saw Jesus on the crucifix, and said, "Sister, let's say the Lord's Prayer." So down on their knees on the floor they got to say the Lord's Prayer. I gave Sister Mary Louise the pills and went down the hall to write some orders. Finally Sister Mary Louise came rolling down the hall, convulsing, and I said, "What did you do? Did you give her the pills?" "Yes, I gave her the pills." "How did you do it?" "It was easy. When we got to the end of the Lord's Prayer, she took one for the Father, and one for the Son, and one for the Holy Ghost."

Psychiatrists Are People, Too

Bob Daugherty called me in 1961 and asked me to coordinate a WICHE-sponsored course. I jumped at the chance, and I have been involved ever since. You might ask me what I've learned. I've learned that psychiatrists are people with the usual hang-ups. I learned that, believe it or not, psychiatrists don't bore holes in your head and let out the sand.

I find that psychiatrists can counsel and point out. They can confront people; they can assist them; they can support them and empathize with them. But they can't cure anyone unless the person has a certain amount of desire and understanding. I haven't been particularly threatened by psychiatrists; they're people. I find, though, that a great number of my friends in medicine are threatened by them, along with their wives, and certainly my patients.

Maybe they're not as wise as one might think. Frankly, though, because Bob Johnson, Reid Kimball, and George Kjaer have made me more acutely aware of what goes on in my practice, the amount of psychiatric material that had been there, under my nose, in the past is more frequently recognized. If you ask me what psychiatric principle, what nomenclature, or what kind of group process I have been involved in, I will probably stand mute and say, "I don't know. I don't know what I've learned. Certainly I am more comfortable, I can recognize the pathology better." But I really don't consider that I have learned any great amount of psychiatric material, as such.

Looking for Clues

Possibly psychiatrists aren't aware of the amount of psychological pathology that routinely goes through a G.P.'s office every day. I don't pass up the clues as I used to. When the people give me the edge, I think I can turn the page a little better, and I am not as threatened by turning the page and seeing what's under it. As far as specific areas are concerned, I've been involved in a considerable amount of sex counseling. I discuss this relationship with every soon-to-be-married couple. I've been involved in counseling a number of adolescents. This need not be long-range counseling. This can be two minutes in the middle of looking at the throat. Actually, this is quite productive, and frequently opens the door to later discussions.

I've learned a lot about drugs. I haven't learned it from you; I've learned it from the kids in my office. I'm not afraid of saying, "What's it like to get high on some LSD?" "Why do you take that junk, anyway?" It's an easy relationship that you pick up along the line, and it comes out comfortably. If you say, "How many kids in your school take that stuff, anyway?" It is amazing, they just open up. I can handle the adolescent malingerer much better. I would wager

that, in my little office, I have, at any given time, one to two kids who are malingering to stay out of school or have the psychosomatic bellyache or headache that comes on every day and has mother absolutely frantic.

Education Has Provided Perspective

I'm not as concerned or worried as much about the depressed patient, frankly asking him what kind of method he is going to use the next time he tries suicide, and then making a contract with him that, before he does it, he is going to let me know so we can talk about it. This used to really hang me up; I was afraid that maybe that was going to kick a patient over, and he would think of the right kind of gun next time.

Dr. Hardin Branch yesterday made a comment which I immediately took issue with. He was wondering if, perhaps by educating G.P.'s and other physicians who are not psychiatrically oriented, we would find that they would be getting in too deep in psychotherapy. Maybe they would be taking on something which should be treated by a psychiatrist. I don't think this is true. I think that, in the past, I allowed the psychiatric pathology to walk out the door with his sore throat, and he never had an opportunity to get to a psychiatrist. I also believe that I am probably referring more people to the psychiatrist, and my referrals are better. I am convinced that anyone who leaves my office to see a psychiatrist is better oriented. I think that I can reduce his level of anxiety and prime him for the psychiatric consultant, just like I prime a person who is to have a uterus out, or a breast biopsy, or whatever else you might refer to any other type of physician.

There is another area in which I think my experience with the WICHE programs has been very helpful, the area of nonverbal communication and reality therapy. In 1965 I underwent a tragedy in my home; we lost a 17 year old son. A number of my well-meaning friends felt that I needed to be busy, so I was conned into accepting the vice-presidency of the county medical society. The president of the society died, so I became president of the county society. At the same time, I had been elected chief of staff at our hospital. So for a while I was chief of staff and president of the county medical society, and I just rolled back and forth from one job to the other. I had the dubious privilege of chairing innumerable meetings. The experience I had gained allowed me to "read" the participants better and to place responsibility where it belonged more effectively.

Behold a Compatriot

I suppose it will be years before you gentlemen will be able to discern whether you really begat a monster or a man who eats into your

conscience and wallets in the future, or whether you actually begat a compatriot. I believe it will be the latter.

THE CON SIDE

Richard Panzer, M.D.
Clinical Instructor in Psychiatry
University of Oregon

What we must not lose sight of, and what I think this program does lose sight of, is that we are dealing with individuals in a system and that the people in it don't like to be thought of as a system. It was brought out yesterday that physicians object to having someone say, "We are going to upgrade the quality of care you give." These people that we are talking about teaching are egoists, even as we are ourselves. We are in this because we like doing it, not because of larger altruistic concerns. It was suggested to me that if we had as our goal, in teaching a course, making it more fun for the physicians, making our habits more fun, making it more romantic—which is after all the reason we got into medicine in the first place—that we would be successful. We can't succeed if we talk about helping to prevent psychiatric illness by making it more possible for physicians to identify this illness before it becomes crystallized.

Physicians Ask for Facts

So today I will present to you comments from physicians in courses. I am teaching my third one now in a little over a year's time. I am sure you have all heard objections made by men in the courses, but I don't think we take them seriously. The one that I hear most frequently is, "It's too fuzzy. I want facts. I want to know something about psychiatry. I want you to give me some answers to some very specific questions I have. I want something I can use." Most of us are convinced that the process we use in teaching is a good one, that it fosters improvement in the physician and his delivery of health care. But we must listen to the man. He wants some information about psychiatry which, it has already been pointed out, he certainly did not get in medical school. I think there is a moving away from the didactic side of things which is not good.

Another one that I hear is, "I haven't enough time to spend two hours a week for 10 or 15 weeks." I think we ought to be flexible in how we set up these courses. Many of us are, but this is another complaint that I hear: "It's group therapy. Who wants that?" I am sure we have all heard that. I think we have to identify the package that we are delivering and do that very early in the process of setting up the course. I hear, "It's too dragged out. When I go to attend a course, I want it to be concentrated—like get in, get it, and get out."

Someone in the group never fails to bring up, "You're teaching liberalness, permissiveness, and this is dangerous. You know what's

happening to the kids today." They want techniques, prognosis, drug doses, and so on. I think generally we are insulting them if we don't listen to that and respect it.

You hear other comments: "It's my own home town; I want to get out of here; I want to go away someplace." "You're from someplace else. How can you possibly know what we have to deal with here? You don't know what's going on here." "Why two of you? You disagree and that confuses me. Why not just one of you?"

The reluctance to bring patients into these courses, particularly in the beginning, the first time the course is taught, has to be respected. I've heard them compared to animals in a zoo, and I'm afraid I have been partner to a time when that analogy wasn't too far wrong. Then I hear, "It's fine for you to say to spend half an hour or 45 minutes with my patient, charge him $25 or $30, but they know that I am not a psychiatrist, and I know it too. If they are going to pay that kind of money for that kind of treatment, then they ought to go to you." Again I think these issues have to be dealt with, not just brushed aside.

The Dilemma

Then, of course, there is the summary comment that many of them make: "I have too many patients every day to deal with their emotional problems anyway. I want you to tell me what pills I can give, and when that won't work, I want your telephone number so I can refer them to you."

The only positive comment that was a criticism that I could think of, in writing these down, was one that was made to me in Missoula, and that was, "Why only once a year?" Why not have this course taught at least twice and maybe three times a year?" I think that we have a responsibility to the men whom we are trying to have accept this program, and we have to listen to their complaints and do something about them. It puts us in the position of being responsible for our brothers. Perhaps after we make ourselves more relevant to them, we can share with them some of our ideas of what makes for a better doctor and what makes medical practice more fun.

THE CON SIDE

John H. Waterman, M.D.
Associate Professor, Clinical Psychiatry
University of Oregon
WICHE Field Consultant on G.P. Program

One of the things I think has to be considered seriously is the expense of this procedure, particularly in the rural areas where it costs maybe $200 or more a trip just to send the teacher to the class. When you have ten or 15 trips like that, it really runs into money. If the group is no more than six to eight physicians, when you consider the cost per student, it is pretty high, and it is worth thinking about. This isn't so big a problem in the cities, but it is certainly a problem in the rural areas. There are other questions to consider. Is it worthwhile to penetrate rural areas to help the G.P. deliver better medical care by being more understanding? Maybe many people who live in rural areas like to live there, and many are willing to accept inferior medical care because this is part of the frontier.

Motivation Considered

Why should we go out and try to change it? Maybe some of these physicians that we are trying to go out and help to be more understanding and deliver better medical care are merely out there to make money. Sometimes it seems that way. You'll find a young man who'll go to a rural area and work around the clock for a while, build up enough money to buy a few ranches, and then desert the community and go into a specialty. You wonder what their motivation really is and whether they would benefit from these courses. Are we the people who should go in and try to do something about this or not?

There are three aspects to this problem, if we are going to help an area deliver better medical care; (1) teaching of the physician to deliver better medical care; (2) giving some kind of service to the community because you can't expect the G.P. to give all the psychiatric service to that community; and (3) education of the community. You have to do it as it is being done in Nevada, where several of the traveling teams are giving this service to the community, while at the same time helping to educate the physicians. Where we have just gone in and educated the physician and not taken into consideration those other two points, the education of the community and the delivery of some kind of service, we have failed, too. We should consider the whole economy of an area because, in order to get better doctors to go to a rural community, you need better schools. A lot of doctors don't want to have their children go to inferior schools. In order to get better teachers you must have better medical care. And it becomes a

vicious circle. You must have better living conditions. Are we going to have to be responsible for that, too?

Another thing, why is it that we, as psychiatrists, are the ones who are pushing postgraduate education for physicians? Is it because we are altruistic or is there some economic factor in it? We psychiatrists are so busy now that we are not threatened by the general practitioner taking over some of our work. The point was made that medical schools aren't doing a good job teaching psychiatry, that the men graduating today at this conference don't have any better understanding of psychiatric principles than graduates did ten years ago. But the students today are far more interested in doing things for people. Students are going into the California high schools to consult with pregnant girls. In Portland the medical students come with all kinds of interest to get into the schools with our school workers to visit our jail, work with prisoners, and things like that.

We have a collegiate companion program going this year where each student in college has an elementary school child as a companion. This has to do with the feeling of youth today, that they are fed up with this impersonal, rigid, welfare system that we have in this country. They want to do something for a kid, right now. They have a live kid to talk to and a live kid to do something with. Our medical students are thinking the same way. Why should we be teaching the G.P.'s already out there when we have a new crop coming up that is going to produce better physicians?

Psychiatrists Do Not Understand G.P.'s Problems

One last criticism. Why do we go out trying to educate G.P.'s when psychiatrists as a group don't understand any of the problems of the G.P.? Of course these teacher-training institutes of ours are to help teach us to be a little more aware of the G.P. and to be able to help him. But I still think it is a valid criticism, and I think we have to look at it carefully.

I'd like to make one remark that I think has been made already by one of the members of the "Con" team: Why do I still feel uncomfortable with psychiatrists telling a general practitioner or family doctor how to practice? He is doing things that I can never do. I sometimes think that we ought to have an opportunity to be in his office for a while to understand what is going on. That is essential. You can't go around telling a general practitioner how to practice. And you can't go around telling him that you're going to teach him about psychiatry. It just doesn't work. We made that mistake ten years ago. You have to let him teach you something first, and he has to understand that you're not there to teach him how to practice medicine. He will respect you for that. He can understand that you are only

there to share with him some of your ideas about people so that he can carry the ball.

DISCUSSION SUMMARY

C. H. Hardin Branch, M.D.
At time of Institute: Professor and Chairman,
Department of Psychiatry
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Presently: Consultant, Mental Health Services
Santa Barbara, California

Attitude of the Healing Arts

I would like to think that we, as physicians and members of other healing professions, might have reached this point of altruism without the pressure and criticism of Medicare and Medicaid. It makes me re-evaluate the attitude of the healing arts. We are a confused profession because our economics are confused. We have never quite known whether we were priests, or barbers, or workmen, or artisans, or what. Maybe it's not surprising that, with a welfare state concept applicable to the healing arts, we should wind up in a confused situation in which we are now trying to pyramid our efforts up, down, or laterally by providing various other kinds of healing people.

We've always had difficulty, particularly we in psychiatry, in demonstrating what we have done with our patients. The surgeon can point to an incision; the internist can quite often point to a prescription; the obstetrician can point to a baby. We can't point to very much, and we sound a little wistful at times when we talk about the fact that all we are doing is talking with our patients. They, nonetheless, are functioning better. We can feel this, but this feeling is not very persuasive in some areas; and sometimes we are not very convinced that what we are doing with nothing but our personalities really has this amount of validity.

Pragmatic Approach

We need a very practical, pragmatic approach to all this G.P. education in our clinical practice. It is going to be essential that we find the *locus minoris resistentiae* from a therapeutic point of view, and we are not doing that. We were talking this morning, in the group, about a house call. I would be willing to bet that, if you did make house calls on the patients you have in psychotherapy, you would find that modification of a family traffic pattern, or another bathroom, or another television set might possibly alter that household from a noxious situation to a helpful situation. If bumping into each other on the way to the television or the bathroom aggravates a neurosis, it might be a lot cheaper to buy another television set or add a bathroom than to spend many, many hours talking about why the person feels anxious. We must train people to do things. We must look

at what is the place of least resistance from a therapeutic point of view.

The persistence of quackery indicates that patients are not very critical, and, consequently, we have to be critical for them. Their satisfaction must not be the only footrule that we use in determining the excellence—or lack of it—in what we do.

As a retiring member of a medical school faculty, I can tell you what you probably already know; you must not look for guidance in these areas to medical school faculty. Many of them do not know what you are talking about, and those who do know what you are talking about don't want to hear about it.

We talk a great deal about the value of the old-time family physician. We say this from our vantage point as specialists who would not know one thing out of the particular field in which we operate. We talk about rural practice and the delights of rural practice, and being the complete physician, and treating the patient as a whole. Nobody on the medical school faculty knows anything about rural practice or any of these other things, unless he happens to have a federal grant which makes it possible for him to get out in the rural areas. You must give your medical school faculty some guidance. Medical schools are beginning to try to develop family practice departments. This is a case of the blind leading the blind.

You must remember also that the old-time family practitioner, if he ever existed, existed at the lowest point of American medicine. Chronologically and historically, this old-time family practitioner was practicing such lousy medicine that the Flexner reports pushed the whole thing back into academic medicine, which is what we know today. Somebody has said that what we need is a reorientation and a return to the good old-fashioned patient. The delivery of medical services is like the whole situation in our society, the most important and weakest link in the whole science-to-consumer chain.

An Impossible Demand on Physicians

We are inclined to feel that we have to play both ends of this situation, provide exquisite technical skill which our patients demand because they watch television, and assure them of our ability to relate to them personally almost *ad infinitum*. But you can't be both places at once. You cannot be attending postgraduate courses and be at home on call seven days a week, 24 hours a day. Yet in essence this is what our patients say they want. I'm not sure they do. I think that some of us, particularly in the nonmedical sense, may be imaginative enough to think about new kinds of personnel in terms of these actual needs. Maybe we do need Bob Daugherty's kamikaze butterfly, maybe we need a person who can manipulate medical facilities without necessarily

having to provide them himself or herself. Maybe this is what we really want, and maybe some of you are imaginative enough to supply this need.

Medical Care in Rural Areas

Going on to another thing very rapidly, we are talking about providing rural physicians for outlying areas. I don't know how we are going to accomplish this mission. The trend is away from the rural areas. It's back to them for some living purposes, and it may well be that the suburbs can create a whole new kind of culture. But most physicians are going to have to be regarded in some extra way for working in these isolated areas, unless they just happen to be the kind of people who like this sort of thing. Many of the people I have talked to who were practicing in rural areas are concerned about the isolation, the lack of time off.

Draft?

Maybe the way that we are going to have to solve this is by governmental assignment of people to these areas as part of their training or part of their licensure procedure. Maybe we are actually going to have to have a civilian doctor draft to fill these areas. I did, at one time, in California. The association with the people and the sense of accomplishment when I did deliver babies at home were romantic and interesting, but I don't know that I would have liked to have kept it up indefinitely. It gets pretty cold sometimes, and I did get pretty tired of being called out in the middle of the night. Would I have liked it if I had made a lot of money doing this? I don't know. I didn't make a lot of money doing it. It was a pleasant kind of practice. The point is, I have tried to think of what it would take to lure me back out into the rural general practice, and I can't think of anything. What can we do as a group of educators who are concerned about it when we try to point out that this is something the public needs? Okay, it needs it, but are we going to produce people who have a burning desire to smash themselves to bits on the exigencies of private practice in Sorghum Center, Iowa? We need a new approach to this. Maybe we could get somebody who could manipulate medical facilities and get a great deal of satisfaction from it, and this would be the kind of person we'd want in these rural areas.

There are other things we could do. I would like to take our psychiatric residents and send them out for a tour of duty in rural practice, replacing the physicians who could then come in for a couple of months of psychiatric work with us on the assumption that this is what they want to do. Herb and I tried to do this some time ago. We didn't get any takers, but it seemed like a nice idea at the time. I

think we would improve the sophistication of our residents and also the perception of the people in these areas.

Military Corpsman, a Model

Lastly, we need to be pretty imaginative about some of the people we are going to try to train to help us. We keep talking about the military corpsman as a model. The corpsmen that I was accustomed to were a superb group of people. I had great affection for them and great admiration for their ability to handle responsibility. But you do have to remember that they were dealing with a highly socially acceptable situation. They had no apologies to make to the people they worked with. They were also dealing with a group of very healthy, young adults.

I don't know that you're necessarily going to produce the same situation with a polyglot patient culture, many of whom are quite sick and can die if you don't watch. You put them under the care of people who are apologizing for not being quite something or other, nurses' assistants or technicians. I think we need to look other places. Somebody suggested to me that pharmacists would be far better partners in this situation than the people we ordinarily think about. I don't know. We do need and are developing in many areas a whole new concept of a person for whom I have no adequate label, and that is the body servant. If you try to get housecleaning and other chores like that done today, you know that you are up into money fast. You are no longer dealing with a $5-a-week person like we had in Florida who cooked all the meals, did the laundry in a washtub out in the alley, and gathered the wood for the fire. They don't exist anymore. You are dealing with high-priced help. Maybe we can figure some euphemisms, some different labels for people who can glorify the service side of things. Many of the things that cause you difficulty if you're a patient in the hospital are these things that appear service propositions.

Nurse Made Humble Service Ladylike

This was what dignified the nurse. The nurse was the first person to make humble service ladylike. And that was the thing that made the nurse so different. It was not a ladylike profession. Who would want to do these menial things? The nurses made this respectable. But this is not what nurses want to do now, and I don't blame them. What they want to do is to get into the same kind of professional activity that other people in the healing arts are in, the technical, skilled scientific work. That leaves the body servant area not taken care of. I don't know any way we can make that an activity that will be sought after by people unless we reward them inordinately

with salaries that are very high, or unless we get a really good public relations person to dignify this whole area. This is something we need. What we are trying to do, I think mistakenly, is to make people feel that, somehow or other, they are joining us in our endeavors if they perform these services to our patients. That is not quite honest. If we can give them adequate labels and a real sense of satisfaction, we may be able to turn some of these things over to some of these other people. But if we get to the point where we are being threatened, you can bet your bottom dollar we are going to start talking about standards.

I had quite a long series of interviews about a creation of a department of family medicine which is what we mentioned a little while ago. I asked some of the surgeons how much surgery they felt a graduate of a department of family medicine could and should do. And they gave me a bunch of sheer balderdash. They thought that, in many instances, it would be perfectly all right for these people to do "uncomplicated appendectomies." Is there a single idiot in this room who would guarantee that he could call his shots on an uncomplicated appendectomy? Certainly not. What are you going to do, scrub up one of the high-priced help and leave him sitting by, while your graduate of your school of family medicine starts in on this uncomplicated appendectomy and then blows a whistle so the guy can come in and rescue him? This is ridiculous. Don't you see what is inherent in their grudging allocation of limited responsibilities to these people? I don't think we ought to kid ourselves that, if economics shift, we may find ourselves getting a little more defensive about some of the things we do.

UNRESOLVED ISSUES AND FUTURE TRAINING INSTITUTE PLANNING

For the past three years, training institute participants have had the opportunity to indicate what they believe to be the major unresolved issues in the provision of psychiatric continuing education for non-psychiatrist physicians and to indicate what specific topics have yet to be covered adequately in their continuing education efforts. Over the past three years there has been a very high degree of stability in the comments made by the institute participants regarding these questions. While this stability is, in part, a function of the fact that a large proportion of participants tend to come to these insitutes on more than one occasion, the consistency of specific comments makes it clear that their reactions are not capricious. The issues identified by institute participants are complex and not easily solved. But because so many of them have been mentioned each year, it might be appropriate to consider these issues and how the training institutes might be used to help resolve them.

Involving Non-Participants

Without a doubt, the single most commonly mentioned issue is how to involve those physicians who currently do not participate in psychiatric continuing education programs. It is generally believed that the amount of time spent in continuing education by physicians is not randomly distributed and that some physicians are deeply involved in increasing their own psychiatric skills, while others are entirely uninterested. Survey data would yield more reliable estimates, but attracting the uninvolved continues to be the greatest concern of the institute participants. While some non-psychiatrist physicians may not know of the availability of continuing education programs and others may be interested but find it is not feasible to take advantage of the opportunities which are present, most participants believe that it is necessary to change attitudes of physicians to persuade them that education is an ongoing process.

Developing Curriculum, Teaching Techniques

A second, but not inconsiderable issue, relates to curriculum and teaching techniques. This issue involves such specific questions as: (1) how to determine appropriate course content; (2) how to identify effective teachers; (3) how to develop alternate teaching modalities for specific settings and specific course content; (4) how to develop continuing education activities in a geographic area formerly without such programs; (5) how to add and to integrate psychiatric content

throughout the formal educational experience; and (6) how to measure effectiveness of continuing education programs. It appears that the participants identify two different specific teaching techniques which they label the sensitivity group model, which focuses on changing attitudes, and the didactical factual model, which focuses on imparting knowledge. Each model can be appropriate, depending on the audience and the objectives of the course. Regarding teaching techniques, participants are interested in exploring the limits of the usefulness of video tapes for teaching purposes and the relative merits of teaching by demonstration versus what might be called "talking about" a particular topic. There was some feeling that psychiatrist-teachers might have to be available to physician-students more frequently than is generally the case if they are to be effective. There was also the expression of some interest in reviewing systematically what has been written about psychiatric continuing education, particularly regarding content and effectiveness.

Who Is the Student?

A third issue relates to the general problem of manpower shortages in the mental health field and the related question of who should be the "student" in psychiatric continuing education. There is considerable awareness of the need to create more mental health manpower, in part, by identifying new sources of manpower. Once such new manpower resources are identified, there is then the issue of whether to provide continuing education opportunities for them or to limit such opportunities to non-psychiatrist physicians.

Improving Delivery

A final issue relates to improving the delivery system for mental health-related services. Several participants of the training institute see this issue as crucial if mental health needs are to be met significantly more successfully than is judged to be currently the case. There appear to be two aspects to the service delivery system issue, namely, the problem of attracting mental health professionals into non-urban areas and the problem of improving the organization of the service delivery system in both urban and rural areas. These concerns seem to start with the assumption that non-psychiatrist physicians, however informative their continuing education experiences, will not be able to meet the needs for mental health-related services without the development of new manpower sources and new strategies for impeoving the manner in which services are made available to persons in need of help.

The Future

It is pertinent to note that planning for future WICHE activities in the field of psychiatric continuing education has included attention

to some of these unresolved issues. First, it is anticipated that statewide surveys conducted among non-psychiatrist physicians will identify where interest in continuing education exists and what the specific nature of these interests includes. Second, an effort is going to be made to explore the feasibility and effectiveness of non-traditional teaching techniques. Finally, efforts have been made to broaden the definition of the recipient population so that psychiatric continuing education experiences would be available to a wider audience.

Regarding future content for psychiatric continuing education programs, the most common suggestion is for topics directly related to improving psychiatric skills of non-psychiatrist physicians. These content areas include:

1. Techniques for case finding and prompt recognition of the psychiatrically disturbed patient
2. Uses and misuses of psychoactive drugs
3. Techniques of interviewing and brief psychotherapy
4. Psychodynamic theory
5. Management of the psychiatric emergency
6. Group dynamics and group behavior
7. The whens and whys of psychiatric referrals

A second group of topics relates to manpower utilization and delivery of services. Included in this group are the following topics:

1. Working with allied professionals
2. Improving quality and organization of medical and psychiatric care
3. Provision of psychiatric services in rural areas
4. Prevention of mental disorder

Finally, a group of topics for continuing education with non-psychiatrist physicians relates to humanism in medical practice.

These topics include:

1. Improving self-awareness
2. Understanding the patient in his social context
3. Patients are people—caring as a therapy

It is important to indicate that these topical areas are highly similar to those suggested in earlier evaluations of psychiatric continuing education training sessions. The fact that these suggestions appear consistently from year to year may help identify the current conceptual boundaries of psychiatric continuing education. It may very well be that these topical interests can never be expected to diminish in importance and may be a constant part of future continuing education programs.

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